LEGISLATIVE SERVICES AGENCY
OFFICE OF FISCAL AND MANAGEMENT ANALYSIS

301 State House
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FISCAL IMPACT STATEMENT

LS 6266 **DATE PREPARED:** Jan 14, 2001
BILL NUMBER: HB 1879 **BILL AMENDED:**

SUBJECT: Medicaid Drug Formularies.

FISCAL ANALYST: Alan Gossard
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FUNDS AFFECTED: X **GENERAL** **IMPACT:** State
DEDICATED
X **FEDERAL**

Summary of Legislation: This bill defines "therapeutic classification". The bill provides that a drug formulary adopted by the Medicaid program or a Medicaid managed care organization (MCO) must provide for at least two alternative drugs within each therapeutic classification on the formulary. It also provides that the Medicaid program or an MCO may require prior authorization of a drug only to restrict access to single source drugs that are subject to clinical abuse or misuse.

This bill also provides criteria for the Drug Utilization Review (DUR) Board to consider in determining whether to approve an MCO's proposal to remove or restrict a single source drug. It also provides that an MCO may remove or restrict a single source drug only under certain conditions. (The introduced version of this bill was prepared by the Interim Study Committee on Medicaid Oversight.)

Effective Date: July 1, 2001.

Explanation of State Expenditures: This bill is expected to increase state expenditures in the Medicaid program. The total exposure to the state may be as much as $3.6 M per year. However, the entire impact is not expected to occur immediately, but may build up over time toward the maximum. (Total expenditures are estimated to potentially increase by $9.6 M with about $6.0 M in federal reimbursement.)

Background: This bill can impact Medicaid expenditures for pharmaceuticals by: (1) restricting the ability to utilize prior authorization (except for single source drugs subject to clinical abuse or misuse) and (2) requiring Medicaid MCOs to provide at least two therapeutically equivalent drugs within each therapeutic class on their formularies. Both of these provisions restrict cost-containment efforts in the Medicaid program and by Medicaid MCOs. Restriction in the ability to use these tools can ultimately result in higher pharmaceutical expenditures, either directly to the Medicaid program or through future managed care capitation rates negotiated with MCOs.

The Office of Medicaid Policy and Planning (OMPP) estimated the per member per month (PMPM) cost for pharmaceuticals paid through the state's Primary Care Case Management program (fee-for-service) as $17.56. The PMPM for pharmaceuticals through the Risk-Based Managed Care (RBMC) program is $10.11. The restriction in the use of the cost-containment tools, described above, could result in higher pharmaceutical expenditures faced by MCOs to the level currently faced in the fee-for-service program: a difference of $7.45 per person per month for the 107,000 recipients in the RBMC program. However, this would represent the ultimate exposure to the state and would not likely be realized immediately.

(Not estimated in the impact provided above are some potential additional administrative costs that may be faced by the state. The extent of this impact has not been established at this time.)

The expenditures of the Medicaid program are shared. The federal government reimburses the state for about 62% of the expenditures, and the state share is 38%.

Explanation of State Revenues: See Explanation of State Expenditures, above, regarding federal financial participation in the Medicaid program.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: Office of Medicaid Policy and Planning.

Local Agencies Affected:

Information Sources: Kathy Gifford, OMPP, (317) 233-4455.